No. 15721

IN THE

United States Court of Appeals

FOR THE NINTH CIRCUIT

RESERVE LIFE INSURANCE COMPANY, a Corporation, *Appellant,* vs. DONALD E. MARR, as Guardian of the Estate and Person of MARY I. MARR, *Appellee.*	No. 15721

Appellant's Reply Brief

On Appeal from the District Court of the United States for the Eastern District of Washington.

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C. W. HILL PRINTING CO.

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AUTHORITIES CITED

CASES

CASES—Continued

TEXTS

EVIDENCE

The Appellee has taken liberties with the undisputed evidence and testimony submitted herein that must be corrected. On pages 2 and 3 of the Appellee's Brief, he would have this Court believe that the medical condition of the plaintiff as it existed when she was placed in the Jane O'Brien nursing home facilities, continued thereafter until approximately six months before trial. That this is not so is evident from the testimony of the attending physician, Dr. Rowe, who stated that her condition had stabilized after a few weeks. From that time forward, her condition remained the same and she required only nursing home care. Defendant's Exhibits 15 and 16, clearly indicate that Dr. Rowe himself considered her treatment and his visits as nursing home care. Defendant's Exhibit 15 is an Attending Physician's Statement, dated May 3, 1956, wherein Dr. Rowe referred to his professional visits as "Nursing Home Calls." Defendant's Exhibit 16, consists of Dr. Rowe's own office records of billing and accounting and therein his professional calls were designated as nursing home calls by using the abbreviation "N.H.C."

Appellee draws the court's attention to the opinion of John Canwell, a shareholder, officer and director of the corporation owning the Jane O'Brien hospital, that the facilities constituted a recognized hospital. His opinion was based upon observations of hospitals situated in Prosser, Kennewick, and Lake Chelan, all in Washington and others in Idaho and Montana. In the Transcript of Record, pages 72 and 73, John Canwell, on Voir Dire Examination, testified as follows:

"Q. What institution was it concerned with?

A. We had the Prosser Hospital, Kennewick Hospital, Lake Chelan Hospital, St. Joseph's Hospital in Montana, Bonner County Hospital, and Sandpoint.

Q. These are all generally recognized hospitals, is that correct?

A. They are all recognized hospitals.

Q. They maintain surgeries, is that correct?

A. Yes.

Q. And maintain an active laboratory, perform obstetrics, that type of hospital is what you are familiar with, is that correct? A. Yes.

Q. And they generally had a staff of physicians supervising the operation of the institution; that is, a staff (31) physician, reviewing procedures, treatment record, and so forth?

A. Yes, I believe all of the hospitals had medical staffs."

Recognized licensed hospitals in the area of Eastern Washington, Northern Idaho and Western Montana maintain surgeries, laboratories and facilities under the supervision of a medical staff according to the testimony of Mr. Canwell himself. The testimony of Lawrence Trousdale, an expert witness, administrator of a licensed hospital and a Trustee of the Washington State Hospital Association substantiates that of John Canwell that surgeries, laboratories and medical staffs are prerequisites for any institution in this area that holds itself out as caring for the acutely ill. The learned trial judge in rendering his oral opinion, misconceived this very point when he spoke of hospitalization in an "identical type" of institution as not being covered in Spokane, Wash-

ington, but being covered if occurring in a smaller community. Confinement, whether it be in Spokane, Prosser, Kennewick, or elsewhere would not be covered under the insuring agreements herein where the institution failed to maintain a surgery, or a laboratory or a medical staff responsible for the supervision of its facilities. As is evident from Canwell's testimony, the learned trial judge was in error in drawing the conclusion that these smaller community, licensed hospitals, did not provide laboratory and surgical facilities under the supervision of a competent medical staff.

Appellee states on page 4 of her brief as follows:

> "Jane O'Brien Hospital at all times pertinent to this case had a *laboratory,* x-ray equipment, permanent and full time facilities for the care of over night residents, *each of which was under the supervision of the licensed doctor of medicine* and had a graduate registered nurse always on duty, with hospital charts for each patient." (Emphasis supplied)

Appellee makes no reference to any portion of the Transcript of Record, and of course, this emphasized portion is unsupported by the Transcript of Record. The Appellee has taken no issue with the Appellant's statement of the Evidence with regard to the lack of a laboratory and a surgery, and the absence of supervision by a licensed Doctor of Medicine over the facilities for the care of over night resident patients. This very failure of the Appellee to challenge or dispute Appellant's statement of the Evidence clearly demonstrates that there is little if any disagreement with respect to the operation and facilities of the Jane O'Brien Hospital at all times material herein.

Appellee next seeks to avoid that portion of the definition of a hospital requiring that the facilities for the care of over night resident patients be under the supervision of a licensed Doctor of Medicine by arguing that each patient has his or her own attending physician. The court's attention is directed to the two policies of insurance introduced herein. Policy No. J-448274, the last sentence of the last full paragraph provides as follows:

> "Benefits provided under this part 1 shall be payable only if such services and materials are furnished at the direction of and under the supervision of a licensed Doctor of Medicine or Osteopathy other than the insured or member of the family group."

Policy No. A-448274, second paragraph, part 1 provides:

> "Benefits under this policy shall be payable only if such confinement is at the direction of and under the supervision of a licensed Doctor of Medicine or Osteopathy other than the insured or member of the family group."

Each policy specifically provides that the confinement must be under the supervision and direction of a physician. By clear and unambiguous language, not only the hospital facilities, but also the patient must be under the supervision of a licensed Doctor of Medicine.

The Appellee, on page 6 of her brief, alludes to a claim for confinement at the Jane O'Brien Hospital during 1954-1955 paid one James W. Reigart. A Specimen Policy, Defendant's Exhibit No. 13 was admitted into evidence. An examination of this policy will indicate that it contained no definition whatsoever of a hospital. At the time the claim was made, the Appellant conducted an investigation. This Court's attention is directed to Defendant's Exhibit No. 14,

an Information Report submitted by Dorothy Blage, Administrator, relating to the nursing home. When the claim of Reigart was paid, the Information Report was marked "OK except policies defining 'Hosp' Watch claims closely—4/26/55 JWA." In the absence of a definition, this claim would have fallen within the rule that where the contract of insurance fails to define the term hospital, the courts will follow the dictionary meaning. For examples see:

> *McNichols v. Denver,* 209 P. (2d) 910 (Colo.—1949); *National Bankers Life Ins. Co. v. Hornbeak,* 266 S.W. (2d) 228, (Tex.—1954).

It is also a well recognized rule of law that the fact that an insurer saw fit to pay a claim under the terms of a then existing policy, prior to the present litigation, whether because the language was different, or the insurer was not in full possession of all the facts, or the amount involved was inconsiderable, or out of sympathy or otherwise, would not estop it from insisting that in the present action, the plaintiff must bring himself within the coverage of the policy.

> *Myers v. Metropolitan Life Ins. Co.,* 33 A. (2d) 253, (Penn.—1943);
>
> *Washington Nat. Ins. Co. v. Craddock,* 109 S.W. (2d) 165, (Tex.—1937).

ARGUMENT

The Appellee, for the most part on pages 6 through 12, discusses the familiar rule of construction that where a contract of insurance is ambiguous or its meaning in doubt, it will be construed most favorably for the insured. With this general rule the Appellant has no quarrel. The court's

attention is directed to the fact that the trial court did not find the policies herein ambiguous or rely upon ambiguity to sustain its judgment. Likewise, Appellee is unable to point out in any fashion how the definition of hospital, identical in both contracts of insurance, is ambiguous or susceptable to more than a single reasonable meaning. The very silence of the Appellee's Brief with regard to any portion of these definitions being ambiguous, makes it obvious that they are not so. Where the policy, considered as a whole, is clear, precise, and unambiguous in its terms, and its sense is manifest and leads to nothing absurd, there is no field for resort to rules of construction, such as the Appellee cites, to give effect to the policy. 1 *Couch on Insurance,* Sec. 166 Pages 326-327. The rule that an insurance policy must be construed strictly against the company and liberally in favor of those afforded protection by it has no application where the provisions of the policy are neither ambiguous nor difficult of comprehension. The court is not at liberty to revise a contract under the theory of construing it. *Jefferies v. General Cas. Co.,* 46 Wn. (2d) 543, 283 P. (2d) 128, (1955). While ambiguous provisions of an insurance contract will be construed most strongly against the insured, the court is not entitled to disregard plain, explicit language nor give an interpretation at variance with the clearly disclosed intent of the parties. *Davis v. North Am. Acc. Ins. Co.,* 42 Wn. (2d) 291, 254 P. (2d) 722, (1953). See also the cases cited in Appellant's Brief, pages 18, 19 and 20 which are relevant to the above.

Beard v. Peoples Ind. Life Ins. Co. of La., 5 So. (2d) 340, cited by Appellee on three occasions, seems clearly in accord with the Washington authorities cited by Appellant:

> "In the construction and interpretation of contracts of insurance, just as with other contracts, the intention of the parties is of paramount importance. This intention is determined in accordance with the plain, ordinary and popular sense of the language which they have used in the agreement, and by giving consideration,
>
> on a practical, reasonable and fair basis, to the instrument in its entirety.
>
> "If the intention is clear, the courts are without right to change the contract in any particular; it is the law between the parties. But if the policy's language is uncertain or ambiguous, and more than one construction is possible, the construction most favorable to the insured will be applied. Also, if one of two possible interpretations would lead to an absurd conclusion it must be abandoned, and that which appears to be more consistent with reason and probability will be adopted."

Manifestly, the Appellee has failed to bring her loss within the terms of the insuring contract for the reason that the Jane O'Brien Hospital could not meet the requirements of the hospital definition in three material aspects, i.e.: it maintained no surgery or laboratory and its facilities for the care of over night patients were not under the supervision of a licensed Doctor of Medicine. The rules of construction cited by Appellee provide her no assistance and have no bearing on the case at bar.

Appellee next argues on page 9 that the Appellant was not harmed by the failure of the Jane O'Brien Hospital to meet the provisions of the definition with regard to facilities and medical supervision. Pages 15 and 16 likewise allude to the argument that the nursing home facilities and its supervision were sufficient for the care and medical attention required by the Appellee. At the time the parties

entered into their contract of insurance, it was intended that certain hospitalization benefits would be available for confinement at a particular type of hospital. By their contract, they agreed and stipulated as to what would constitute a hospital. Had they intended coverage in a sanitarium, a rest home, or a nursing home, providing for the care and nursing of semi-invalid, postoperative, or convalescent patients, the contract would have so stated. The insuring agreement further provided that the insured be *necessarily confined* to a particular type of hospital. It is submitted that the testimony of the attending physician, Dr. Rowe sufficiently answers this argument wherein he stated that had the Appellee been confined to a licensed hospital, one providing a laboratory, surgery, and medical staff, she would have not remained there more than several weeks or no longer than one month. Assuming for the sake of argument, that she had been admitted to one of the four licensed hospitals situated in the City of Spokane, and after two to four weeks, discharged therefrom and taken to the Jane O'Brien Hospital, a licensed nursing home for recovery and care, and recalling that Dr. Rowe, the attending physician testified that this is the usual procedure in stroke cases, could it be seriously argued that *Rew v. Beneficial Standard Etc. Co.,* 41 Wn. (2d) 577, 250 P. (2d), 956 would not apply and be controlling. It is apparent that the Appellee was not an acutely ill patient at the time she was placed in the nursing home or her doctor would not have had her taken there. According to the nursing home statutes, the Jane O'Brien Hospital is not licensed to accept acutely ill patients and the acceptance of other than convalescent or chronic patients would have been in violation of their license. Mary I. Marr, the Appellee, never needed

the care offered by the type of hospital provided for in the insuring agreement, and had she been admitted to such a hospital meeting those requirements, she would have been discharged within two to four weeks and the liability of the Appellant terminated after such discharge.

Appellee at page 11 argues that the failure of the Appellant to exclude "psychiatric hospitals" distinguishes the *Rew v. Beneficial Standard, Etc. Co., supra.* The court's attention is directed to the fact that during the first approximately 150 days the Appellee was confined to the Jane O'Brien Hospital, it was licensed as a nursing home, not as a private establishment for alcoholics and the mentally ill, and had been so licensed since July 1, 1954. Further each policy, while not excluding as such psychiatric hospitals, does exclude hospitalization benefits for nervous or mental disorders. Had Appellee been confined for a mental, psychiatric or alcoholic reason, there would have been no coverage even though the institution qualified as a hospital under the policy definition.

At page 17 of Appellee's Brief, it is suggested that it can be argued that there is ambiguity in Reserve Life Policy No. J-448274, for the reason that Part 1 fails to specifically refer to Part 10 which defines the word hospital. Policy A-448274 does so refer to Part 2 which contains the definition of hospital. The definition of a hospital is identical in each policy. Both definitions are prominently displayed and preceded by bold faced type "DEFINITION OF HOSPITAL". These two policies were issued Mary I. Marr on the same date, i.e.: May 4, 1954. By the language used, it cannot be seriously argued that the phrase contained in

the definition that "The word 'hospital' whenever used in this policy means * * *", could refer other than to the type of the institution the contract of insurance contemplated. To place such a strained interpretation upon the contract would effect an absurd and unreasonable result. See *Richards v. Metropolitan Life Ins. Co.*, 184 Wash. 595, 55 P. (2d) 1067; and *Beard v. Peoples Industrial Life Ins. Co. of Am., supra.* It has never been asserted that either counsel or the insured were in any way mislead and of course they were not. The brief treatment given this matter is indicative of the unimportance with which Appellee's counsel attaches thereto.

Appellee, on page 16, asserts that the facilities and supervision of the Jane O'Brien Hospital were equal to if not superior to that found in the *McKinney v. American Security Life Ins. Co.*, 76 So. (2d) 630. This is patently erroneous. The MacDonald Clinic in the *McKinney* case was owned and operated by a licensed Doctor of Medicine. With the exception of x-ray equipment and a registered nurse during part of the night, this clinic had all the attributes usually expected and found in a licensed hospital. It is the equipment, facilities and supervision that constitute a hospital.

> "A naked building would not be a hospital. It would require the essential equipment to make it such * * *"
>
> *Railey v. City of Magnolia,* 126 S.W. (2d) 273, (Ark.—1939).

The Jane O'Brien Hospital has never had a surgery or facilities for obstetrics or the administration of anesthesia or

medical supervision or a radiologist or pathologist or a laboratory technician or x-ray technician, all which are services, facilities, and supervision mandatory if an institution is to accept and care for the acutely ill. The MacDonald Clinic was capable of performing these functions with the exception of x-ray equipment. Thus there is a world of difference between this nursing home and the MacDonald Clinic. A licensed nursing home providing registered nurses always on duty and making available to physicians with patients therein, a portable x-ray unit hardly rises to the dignity of a hospital, either under the insuring agreement or as the term hospital is generally understood. That the two insuring agreements contemplated confinement in an institution which could perform these services and provide supervision is clear from its provisions and its schedules of benefits. The Jane O'Brien Hospital can further be distinguished from the MacDonald Clinic in that it has never provided facilities for the delivery of over 150 babies a year or received any of its revenue under health and accident policies or been recognized by insurance carriers who regularly paid claims therein for confinement. Where the State of Washington in licensing institutions for the care of the acutely and chronically ill distinguishes between institutions with and without a surgery, it cannot be asserted that insurance contracts making the same distinction are either unreasonable or unrealistic.

Counsel for Appellee at page 19 of his Brief questions the cases cited by Appellant which hold that the burden of proof rests upon the insured to prove the occurrence of expenses within the coverage of the hospital and medical care

insurance contract. It is to be observed that Appellee fails to cite cases in support of her opinions. In addition to the cases cited in Appellee's Brief, page 17, the writer cites the following as substantiating his construction of the general rule.

> *Commonwealth Life Ins. Co. v. Wood,* 206 Okla 203, 242 P. (2d) 446, (Okla.—1952)
> *Preferred Life Ins. Co. v. Stephenville Hospital,* 256 S.W. (2d) 1006, (Tex.—1953)
> *Imperial Life Ins. Co. v. Thornton,* 138 S.W. (2d) 295, (Tex.—1939).

On page 22 of Appellee's Brief, 12 *Am. Jur., Sec.* 343, *page* 900, is mentioned with regard to substantial performance. As is apparent this quoted portion of *Am. Jur.* is to be found under contracts generally. The balance of that paragraph quoted by Appellee is as follows:

> "Although a plaintiff is not absolutely free from fault or omission in every particular, the court will not turn him away if he has in good faith made substantial performance, but will enforce his rights on the one hand, and preserve the rights of the defendant on the other, by permitting a recoupment. Strict compliance with every specification of a contract is not of the essence of a contract, unless made so by the terms of the contract or by necessary implication. Accordingly, where one party to a contract has received and retained the benefits of a substantial partial performance of the agreement by the other party who has not fully performed all his covenants, the first party cannot retain the benefits and repudiate the burdens of the contract, but he is bound to perform his part of the agreement, and his remedy for the breach is limited to compensation in damages. Where a contract has been partly performed by one party and the other has derived a substantial benefit therefrom, the latter cannot refuse to comply with its terms simply because the former fails

> to complete performance. Where there has been part performance and there is a breach of a promise which goes to only a part of the consideration and the breach may be compensated for in damages, the breach does not relieve the other party from his obligation to perform his promise. In order to operate as a discharge, the partial failure to perform must go to the very root of the contract. But a breach that goes to the essence of the contract justifies a refusal of the other party to perform his promise or discharges his obligation to perform, even though there has been part performance. In other words, a breach of a promise which goes to the whole consideration gives to the injured party the right to treat the entire contract as broken. Where the failure to perform part of a contract is in regard to matters which would render the performance of the rest a thing different in substance from what was contracted for, the party not in default may abandon the contract. A plaintiff who has committed a substantial breach cannot recover where the promises are dependent. It may be observed that where there is such a material breach, the plaintiff has not substantially performed."

The following cases cited in Appellee's Brief have to do with construction of contracts and not insurance agreements:

> *Woodruff v. Hough*, 91 U. S. 596, 23 L. ed. 332;
> *Lautenbach v. Meredith*, 240 Iowa 166, 35 N.W. (2d) 870;
> *Winfield Mutual Housing Corp. v. Middlesex Concrete Products & Excavating Corp.*, 39 N. J. Supra 92, 120 A. (2d) 655.

Newport v. Newport & C. Bridge Co., 90 Ky. 193, 13 S.W. 720, 8 L.R.A. 484, pertained to compliance with a city ordinance while *Ambassador Bldg. Corp. v. St. Louis Amsterdam Theatre,* 238 Miss. App. 600, 185 S.W. (2d) 827, related to a lease construction and *King v. Hintze,* 2 Utah

(2d) 166, 270 P. (2d) 1095, to the construction of a mining agreement. Not any of these cases has any real bearing on the issues under consideration other than as they relate to contracts generally.

The only case dealing directly with an insurance contract is *Porter v. Trader Ins. Co.*, 164 N. Y. 504, 58 N.E. 641, 52 L.R.A. 424, in which the Court held that substantial compliance means that the insured has complied with all of the terms and conditions of the insuring agreement other than those of an unimportant, trifling or immaterial nature. See *Inter-Southern Life Ins. Co. v. Cochran,* 83 S. W. (2d) 11, (Ky.—1935) involving change of beneficiaries and *La Hood v. National Union Fire Ins. Co.,* 153 So. 695; (La.—1934) involving an iron-safe clause in a fire policy. While generally speaking the rules established for the construction and interpretation of general contracts are applicable to policies of insurance, the authorities cited by Appellee are founded upon the proposition that substantial performance, being other than literal, full or exact performance in every detail, will prevent a forfeiture, the other party is entitled to compensation or deductions from the contract price because of the defective performance. For a Washington case concerning compliance with a lien notice statute requirement, the Court's attention is directed to *Fidelity & Deposit v. Conway,* 14 Wn. (2d) 551, 128 P. (2d) 764, (1942). The court correctly analyzed the danger at page 560 of their opinion in allowing a substantial departure from the statute under the theory of substantial compliance, as the result would be, in effect, to nullify the statutory provisions. As has been pointed out earlier in this Reply Brief, the Jane O'Brien Hospital deviated from the hospital definition in

a substantial and material degree, as distinguished from trifling, unimportant and immaterial in nature. The lack of a surgery or a laboratory and lack of any supervision by a licensed Doctor of Medicine over its facilities for the care of over night resident patients very substantially varies from the definition upon which the parties agreed to be bound. This court is not at liberty under a theory of substantial compliance to rewrite the policy definition or strike therefrom these three material contract requirements.

Appellant acknowledges the general applicability of Rule 52(a) of the Rules of Civil Procedure (28 U.S.C.A. Sec. 723c) on appeals as pointed out in Appellee's Brief on pages 24 and 25. However, this rule has certain modifications which bear on the effect of Findings of Fact where they are based upon uncontradicted testimony and evidence. This qualification to that portion of Rule 52(a), providing that:

> "* * * Findings of Fact shall not be set aside unless clearly erroneous, and due regard shall be given to the opportunity of the trial court to judge of the credibility of the witness" * * *,

was considered by Circuit Judge Garrecht of the Ninth Circuit, in the case of *Home Indemnity Co. of N.Y. v. Standard Acc. Ins. Co.*, 167 F. (2d) 919, (1948). Briefly, an insured became involved in a hit and run accident and during the several weeks following the accident, told his insurance carrier, the police and others, four different versions of the accident before entering a plea of guilty to a criminal charge. The insurance carrier denied coverage for the reason that the insured had failed to cooperate with

the company as required by the policy. The trial court held that the insurance carrier had not been in anywise prejudiced by the actions or statements or omissions of the insured and that the carrier was bound to enter into his defense.

On appeal, this Court considered the weight to be given to the trial Judge's Findings of Fact and the applicability of Rule 52(a). Like in the matter at bar, there was no serious dispute as to the factual aspects upon which the insurer denied liability under the insurance contract. In the matter at hand, there is little, if any, dispute as to the testimony or documentary evidence and as is pointed out earlier in this Brief, Appellee took no material issue with the evidentiary statement of the Appellant set forth in its Opening Brief. Quoting from this decision, Judge Garrecht held:

> "The court found, however, that the appellant 'has not been in anywise prejudiced by any action or statement or omission of George White.' This is a conclusion of law, or at most, an inference from undisputed facts, which we are in as good a position to make as was the trial court.
>
> "In *United States v. United States Gypsum Company*, 68 S. Ct. 525, at page 541 the Supreme Court, in dealing with a situation comparable to that which confronts us here, said:
>
> " 'Insofar as this finding and others to which we shall refer are inferences drawn from documents or undisputed facts, heretofore described or set out, Rule 52(a) of the Rules of Civil Procedure (28 U.S.C.A. following section 723c) is applicable. That rule prescribed that findings of fact in actions tried without a jury "shall not be set aside unless clearly erroneous, and due regard shall be given to the opportunity of the trial court to

> judge of the credibility of the witnesses." It was intended, in all actions tried upon the facts without a jury, to make applicable the then prevailing equity practice. Since judicial review of findings of trial courts does not have the statutory or constitutional limitations of findings by administrative agencies or by a jury, this Court may reverse findings of fact by a trial court where "clearly erroneous". The practice in equity prior to the present Rules of Civil Procedure was that the findings of the trial court, when dependent upon oral testimony where the candor and credibility of the witnesses would best be judged, had great weight with the appellate court. The findings were never conclusive, however. A finding is "clearly erroneous" when although there is evidence to support it, the reviewing court on the entire evidence is left with the definite and firm conviction that a mistake has been committed. * * *' "

It is submitted that those portions of Findings of Fact VIII, on Appellee's First Cause of Action, and Findings of Fact IV, of Appellee's Second Cause of Action, which held:

> "That there has been *substantial performance* by the Jane O'Brien Hospital according to the definition as set out in * * *" (Emphasis Supplied)

constitutes "* * * a conclusion of law, or at most, an inference from undisputed facts, which * * *" this court is "* * * in as good a position to make as was the trial court."

> *Home Indemnity Co. of N.Y. v. Standard Acc. Ins. Co., supra p.* 923.

Neither the demeanor of the witnesses nor their credibility was seriously involved at the time of trial. Thus this court is free to draw ultimate inferences and conclusions which

the evidentiary findings reasonably induce, where the evidence is entirely documentary or the facts are not in dispute.

See:

Carter Oil Co. v. McQuigg, 112 F. (2d) 275, (CCA 7th 1940)

Smyth v. Barneson, 181 F. (2d) 143, (CCA 9th 1950)
Kaufman-Brown Potato Co. v. Long, 182 F. (2d) 594, (CCA 9th 1950)

Moore's Federal Practice, Vol. 5, Sec. 52.04, p. 2637; 2 *Federal Practice and Procedure*, Vol. 2, Sec. 1132, pp. 832-3.

Appellant does not retreat in the least from its position, maintained in the Opening Brief, that the Jane O'Brien Hospital is not and never has been a recognized hospital within the hospital definition contained in the insuring agreement and, further, that the Appellee was not necessarily confined to a hospital of the type contemplated by the insurance contract for the reason that she did not require that type of hospital service.

Respectfully submitted,

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